

Bamlanivimab | New Patient Enrollment Form

Patient Exclusion Criteria

If a patient meets any of the following criteria, they are not eligible for bamlanivimab infusion therapy:

- 1.) Currently hospitalized due to COVID-19
- 2.) Requires oxygen therapy due to COVID-19
- 3.) Requires an increase in baseline oxygen flow rate due to COVID-19 and on chronic oxygen therapy due to underlying non-COVID-19 related comorbidity

1 Patient Information:

Patient Name: _____ Date: _____

SSN#: _____ DOB: _____ Primary Phone: _____ Work Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

NKDA Allergies: _____ Ht: _____ in/cm Wt: _____ lbs/kg

Male Female Date of First Symptom Onset: _____ COVID Positive Result Date: _____

2 Clinical Information: ARJ policies and protocols to be provided upon request.

| Medication | Dose | Directions | Quantity/Refills |
|--|------------------|---------------------------------------|---------------------------------|
| <input checked="" type="checkbox"/> Bamlanivimab | 700 mg/250 mL NS | Infuse IV per manufacturer guidelines | Dispense: 1x dose No Refills |

RN to start peripheral IV or use existing CVC. RN to administer catheter flushing per ARJ Policy and Procedure.

50ml 0.9% Sodium Chloride: Once infusion is complete, flush infusion line with 50ml 0.9% Sodium Chloride to ensure delivery of required dose.

Inclusion Criteria
At least one of the following criteria must be met to qualify for bamlanivimab therapy

Patient is 12 years of age or older weighting at least 40 kg
Patient Weight: _____ kg Date: _____

Patients must have at least one of the following listed below (check all that apply):

Body Mass Index greater to or equal to 35 Chronic Kidney Disease Diabetes

Immunosuppressive Disease (i.e. CVID) Currently receiving immunosuppressive treatment

≥ 65 years of age ≥ 55 years of age, **AND** have at least one of the following: Cardiovascular disease, Hypertension, COPD or other respiratory disease

Ages 12-17 AND have at least one of the following:

BMI ≥ 85th percentile for age & gender based on CDC growth charts
Visit website: cdc.gov/growthcharts/clinical_charts.htm

Sickle Cell Disease Congenital or Acquired heart disease

Neurodevelopmental disorder Medical-related technological dependence (i.e. tracheostomy, gastrostomy, ventilator and not related to COVID-19)

Asthma, reactive airway, or other chronic respiratory disease requiring daily medication

Adverse Reaction Orders: (Please choose one)

DO NOT DISPENSE: Facility will use their own reaction medication.

DISPENSE ARJ REACTION MEDICATION: Indicated per manufacturer guidelines listed below.

In the event of an infusion reaction (i.e. fever, chills, backache, headache, rigors) the following orders will be followed and physician will be notified.

Note: For mild reactions, patient may be treated and infusion resumed at a slower rate.

STOP infusion. Infuse D5W or NS at 20 mL/hr to keep line open, may increase to 100-250 mL/hr for hydration. May give the following if stopping infusion does not resolve symptoms:

Diphenhydramine
50 mg IV diluted in D5W or NS 50-100 mL, infused over 10-15 minutes or 50 mg/10 mL NS IV push over 2-3 minutes, as tolerated.

Methylprednisolone
125 mg (OR _____ mg) slow IV push over 5 minutes.

Acetaminophen
325-650 mg (OR _____ mg) po at onset of symptoms.

Ondansetron
4 mg slow IV push over 5 minutes or 4 mg ODT.

Epinephrine (1:1000) by weight for use IM or SQ in anaphylactic reaction. May repeat one time. EMS/911 will be called if used.

3 Prescriber Information: By signing I certify that the use of the indicated treatment is medically necessary and I will be supervising the patient's treatment. ARJ Infusion Services has my permission to contact the patient's health plan to obtain any authorizations necessary to enable it to receive payment for services.

Physician Name: _____ Office Contact: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

License #: _____ DEA#: _____ NPI #: _____

Date: _____ | _____
Date: _____

Physician Signature Required - Substitution Permitted *Physician Signature Required - Dispense as Written*

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